SENATE BILL No. 643

Introduced by Senator Chesbro

February 22, 2005

An act to amend Section 1418.81 of the Health and Safety Code, and to amend Sections 14043.26 and 14126.023 of, and to add Sections 5358.4, 14005.95, 14132.43, and 14132.99 to, the Welfare and Institutions Code, relating to health care.

LEGISLATIVE COUNSEL'S DIGEST

SB 643, as introduced, Chesbro. Nursing facilities.

(1) Existing law provides for the Medi-Cal program, which is administered by the State Department of Health Services, and which provides health care services to qualified low-income recipients. The Medi-Cal program is partially governed and funded by federal Medicaid provisions.

Existing law establishes various categories of Medi-Cal eligibility, including certain aged, blind, and disabled persons who are eligible conditioned upon meeting a share-of-cost requirement.

Under existing law, Medi-Cal recipients residing in nursing facilities are entitled to an amount for their personal and incidental needs, computed as prescribed.

This bill would, with respect to recipients required to meet a share-of-cost requirement who have been receiving Medi-Cal funded long-term care for more than 3 months, modify the personal and incidental needs allowance to the 2 months prior to discharge and provide for reimbursement of a portion of the share-of-cost to the recipient at the time of discharge.

Existing law requires that applicants for Medi-Cal provider enrollment status who meet specified criteria may be granted preferred provisional provider status for 18 months. Existing law requires the department, within 180 days of receiving an application package

required for Medi-Cal provider enrollment or from the date of the notice to an applicant or provider that the applicant or provider does not qualify as a preferred provider, to give written notice to the applicant or provider that provisional provider status is being granted for 12 months, the application package is incomplete, the department is pursuing investigation, or the application is being denied for designated reasons, or the department is required on the 181st day to grant the applicant or provider provisional provider status for no longer than 12 months, effective from the 181st day.

This bill would, instead of the 180-day time period, make the time period for processing of an application package for specified independent nurse providers 30 days following the receipt of the application package by the department.

Existing law permits the Director of Health Services to enter into contracts to provide targeted case management as a method of obtaining services for Medi-Cal recipients.

This bill would provide that targeted case management services, as prescribed, would be a covered benefit under the Medi-Cal program for nursing facility residents when medically necessary to transition into the community.

Under existing law, the State Department of Health Services has obtained various waivers of Medicaid provisions generally aimed at enabling more Medi-Cal recipients to obtain the necessary services to reside in community settings.

This bill would authorize the department to seek an increase in the scope of these waivers, in order to enable additional nursing facility residents to transition into the community, but would condition implementation of these amended waivers upon obtaining federal financial participation.

(2) Under existing law, the Long-Term Care, Health, Safety and Security Act of 1973 requires certain long-term health care facilities to include within a resident's care assessment, the potential for the resident to be released from the facility, and requires the resident's plan of care to reflect the care needed to assist in achieving the resident's preference to return to the community.

This bill would require that the plan include services that will assist the resident in maintaining, regaining, and acquiring the skills and level of functioning that would assist in a return to the community. The bill would authorize inclusion of information concerning home- and community-based waivers, and resources that provide or arrange

for housing assistance, within the information concerning community services required to be provided to the resident or the resident's representative.

(3) Existing law, the Lanterman, Petris, Short Act provides for involuntary mental heath treatment for persons who are a danger to self or others by reason of mental illness or chronic alcoholism, including, but not limited to, the granting of a conservatorship for this purpose.

This bill would require the county mental health agency to fund any assessments conducted at the request of a conservatee or his or her attorney in a conservatorship proceeding, thereby imposing a state-mandated local program.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that, if the Commission on State Mandates determines that the bill contains costs mandated by the state, reimbursement for those costs shall be made pursuant to these statutory provisions.

Vote: majority. Appropriation: no. Fiscal committee: yes. State-mandated local program: yes.

The people of the State of California do enact as follows:

SECTION 1. Section 1418.81 of the Health and Safety Code is amended to read:

1418.81. (a) In order to assure the provision of quality patient care and as part of the planning for that quality patient care, commencing at the time of admission, a skilled nursing facility, as defined in subdivision (c) of Section 1250, shall include in a resident's care assessment the resident's projected length of stay and the resident's discharge potential. The assessment shall include whether the resident has expressed or indicated a preference to return to the community and whether the resident has social support, such as family, that may help to facilitate and sustain return to the community. The assessment shall be recorded with the relevant portions of the minimum data set, as described in Section 14110.15 of the Welfare and Institutions Code. The plan of care shall reflect, if applicable, the care

ordered by the attending physician needed to assist the resident in achieving the resident's preference of return to the community*, including services that will assist the resident in maintaining, regaining, and acquiring the skills and level of functioning that would assist in a return to the community*.

(b) The skilled nursing facility shall evaluate the resident's discharge potential at least quarterly or upon a significant change in the resident's medical condition.

(c) The interdisciplinary team shall oversee the care of the resident utilizing a team approach to assessment and care planning and shall include the resident's attending physician, a registered professional nurse with responsibility for the resident, other appropriate staff in disciplines as determined by the resident's needs, and, where practicable, a resident's representative, in accordance with applicable federal and state requirements.

(d) If return to the community is part of the care plan, the facility shall provide to the resident or responsible party and document in the care plan the information concerning services and resources in the community. That information may include information concerning:

(1) In-home supportive services provided by a public authority or other legally recognized entity, if any.

(2) Services provided by the Area Agency on Aging, if any.

(3) Resources available through an independent living center.

(4) *Home- and community-based waivers that may provide support to the resident in the community.*

(5) Resources that provide, or arrange for, housing, shared housing, or housing assistance.

(6) Other resources or services in the community available to support return to the community.

(e) If the resident is otherwise eligible, a skilled nursing facility shall make, to the extent services are available in the community, a reasonable attempt to assist a resident who has a preference for return to the community ~~and who has been determined to be able to do so by the attending physician~~, to obtain assistance within existing programs, including appropriate case management services, in order to facilitate return to the community. The targeted case management services provided by

entities other than the skilled nursing facility shall be intended to facilitate and sustain return to the community.

(f) *Upon a request for assistance or if the facility sees that assistance is needed, the facility shall assist the resident in accessing services to help the resident return to the community. That assistance may include, but need not be limited to, providing information to the county about the resident's care needs for someone applying for in-home supportive services so that those services can be in place on the resident's arrival home, and providing assistance in applying for home- and community-based waiver services.*

(g) A facility shall assist the resident in obtaining or getting the authorization for services and equipment identified as needed in the discharge plan, including, but not limited to, prior authorization for home health care or equipment from Medicare, an HMO, a private health plan, or Medi-Cal.

(h) Costs to skilled nursing facilities to comply with this section shall be allowable for Medi-Cal reimbursement purposes pursuant to Section 1324.25, but shall not be considered a new state mandate under Section 14126.023 of the Welfare and Institutions Code.

SEC. 2. Section 5358.4 is added to the Welfare and Institutions Code, to read:

5358.4. (a) At any time, a conservatee or any person on his or her behalf with the consent of the conservatee or his or her counsel, petitions the court for a behavioral, psychological, psycho social rehabilitation, neurological, supported living, or other professional assessment, to address an alternative placement or the supports the conservatee may need to transition to an alternative placement. Upon receipt of the petition, the court may order the conservator or the public guardian's office to secure the assessment for the conservatee. Funding for assessments ordered pursuant to this section shall be provided by the county mental health agency in the county of commitment.

(b) The assessments shall be conducted by a licensed professional with appropriate training, credentials, and experience. The assessments shall cover, but not be limited to, all of the following areas:

(1) The conservatee's expressed goals.

(2) Documentation of the conservatee's participation in the assessment.

(3) Relevant mental health, developmental disability, or neurological disorder diagnosis information and treatment needs.

(4) Relevant physical health diagnosis information and treatment needs.

(5) A description of the conservatee's psycho social, educational, and vocational strengths and preferences.

(6) Relevant medications and dosages.

(7) Placement alternatives, including community placement alternatives.

(8) A description of relevant community support services that could assist the conservatee in transitioning to an alternative placement.

(9) Peer support alternatives.

(10) Culturally appropriate supports that may assist the conservatee in transitioning to a less restrictive placement.

SEC. 3. Section 14005.95 is added to the Welfare and Institutions Code, to read:

14005.95. (a) This section applies only to Medi-Cal recipients who have been receiving Medi-Cal funded long-term care for more than three months and have been paying a share of cost for that care pursuant to subdivision (d) of Section 14005.12.

(b) Notwithstanding subdivision (b) of Section 14005.9 and subdivision (d) of Section 14005.12, the personal and incidental needs of a Medi-Cal recipient in each of the two months prior to the month of discharge shall be an amount equal to the income level for maintenance for a single individual as provided in subdivision (b) of Section 14005.12.

(c) At discharge, but within five days following discharge of the Medi-Cal recipient from long-term care into the community, the Medi-Cal long-term care provider shall reimburse the discharged Medi-Cal recipient in an amount equal to the difference between the share of cost determined under subdivision (b) of Section 14005.9 and paragraph (1) of subdivision (d) of Section 14005.12 and the share of cost paid and determined in accord with subdivision (b) of this section.

(d) By February 1, 2006, the department shall submit to the federal Centers for Medicare and Medicaid Services a state plan

amendment seeking approval of the personal and incidental needs adjustment authorized under this section.

(e) (1) The department shall adopt emergency regulations to implement this section in accordance with the rulemaking provisions of the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code).

(2) The emergency regulations shall be adopted when necessary federal approvals have been obtained or with respect to which the department determines that federal financial participation is available under Title XIX of the federal Social Security Act.

(3) The initial adoption and one readoption of the initial regulations shall be deemed to be an emergency and necessary for the immediate preservation of the public peace, health and safety, or general welfare.

(4) The initial emergency regulations and the first readoption shall be exempt from review by the Office of Administrative Law, however, the regulations shall be submitted to the Office of Administrative Law for filing with the Secretary of State, shall be published in the California Code of Regulations, and shall remain in effect as emergency regulations for no more than 180 days.

SEC. 4. Section 14043.26 of the Welfare and Institutions Code is amended to read:

14043.26. (a) (1) On and after January 1, 2004, an applicant that is not currently enrolled in the Medi-Cal program, or a provider applying for continued enrollment, upon written notification from the department that enrollment for continued participation of all providers in a specific provider of service category or subgroup of that category to which the provider belongs will occur, or a provider not currently enrolled at a location where the provider intends to provide services, goods, supplies, or merchandise to a Medi-Cal beneficiary, shall submit a complete application package for enrollment, continuing enrollment, or enrollment at a new location or a change in location.

(2) Clinics licensed by the department pursuant to Chapter 1 (commencing with Section 1200) of Division 2 of the Health and Safety Code and certified by the department to participate in the Medi-Cal program shall not be subject to this section.

(3) Health facilities licensed by the department pursuant to Chapter 2 (commencing with Section 1250) of Division 2 of the Health and Safety Code and certified by the department to participate in the Medi-Cal program shall not be subject to this section.

(4) Adult day health care providers licensed pursuant to Chapter 3.3 (commencing with Section 1570) of Division 2 of the Health and Safety Code and certified by the department to participate in the Medi-Cal program shall not be subject to this section.

(5) Home health agencies licensed pursuant to Chapter 8 (commencing with Section 1725) of Division 2 of the Health and Safety Code and certified by the department to participate in the Medi-Cal program shall not be subject to this section.

(6) Hospices licensed pursuant to Chapter 8.5 (commencing with Section 1745) of Division 2 of the Health and Safety Code and certified by the department to participate in the Medi-Cal program shall not be subject to this section.

(b) Within 30 days after receiving an application package submitted pursuant to subdivision (a), the department shall provide written notice that the application package has been received and, if applicable, that there is a moratorium on the enrollment of providers in the specific provider of service category or subgroup of the category to which the applicant or provider belongs. This moratorium shall bar further processing of the application package.

(c) (1) If the applicant package submitted pursuant to subdivision (a) is from an applicant or provider who meets the criteria listed in paragraph (2), the applicant or provider shall be considered a preferred provider and shall be granted preferred provisional provider status pursuant to this section and for a period of no longer than 18 months, effective from the date on the notice from the department. The ability to request consideration as a preferred provider and the criteria necessary for the consideration shall be publicized to all applicants and providers. An applicant or provider who desires consideration as a preferred provider pursuant to this subdivision shall request consideration from the department by making a notation to that effect on the application package, by cover letter, or by other means identified by the department in a provider bulletin.

Request for consideration as a preferred provider shall be made with each application package submitted in order for the department to grant the consideration. An applicant or provider who requests consideration as a preferred provider shall be notified within 90 days whether the applicant or provider meets or does not meet the criteria listed in paragraph (2). If an applicant or provider is notified that the applicant or provider does not meet the criteria for a preferred provider, the application package submitted shall be processed in accordance with the remainder of this section.

(2) To be considered a preferred provider, the applicant or provider shall meet all of the following criteria:

(A) Hold a current license as a physician and surgeon issued by the Medical Board of California or the Osteopathic Medical Board of California, which license shall not have been revoked, whether stayed or not, suspended, placed on probation, or subject to other limitation.

(B) Be a current faculty member of a teaching hospital or a children's hospital, as defined in Section 10727, accredited by the Joint Commission for Accreditation of Healthcare Organizations or the American Osteopathic Association, or be credentialed by a health care service plan that is licensed under the Knox-Keene Health Care Service Plan Act of 1975 (Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code; the Knox-Keene Act) or county organized health system, or be a current member in good standing of a group that is credentialed by a health care service plan that is licensed under the Knox-Keene Act.

(C) Have full, current, unrevoked, and unsuspended privileges at a Joint Commission for Accreditation of Healthcare Organizations or American Osteopathic Association accredited general acute care hospital.

(D) Not have any adverse entries in the Healthcare Integrity and Protection Databank.

(3) The department may recognize other providers as qualifying as preferred providers if criteria similar to those set forth in paragraph (2) are identified for the other providers. The department shall consult with interested parties and appropriate stakeholders to identify similar criteria for other providers so that they may be considered as preferred providers.

(d) Within 180 days after receiving an application package submitted pursuant to subdivision (a), or from the date of the notice to an applicant or provider that the applicant or provider does not qualify as a preferred provider under subdivision (c), the department shall give written notice to the applicant or provider that any of the following applies, or shall on the 181st day grant the applicant or provider provisional provider status pursuant to this section for a period no longer than 12 months, effective from the 181st day:

(1) The applicant or provider is being granted provisional provider status for a period of 12 months, effective from the date on the notice.

(2) The application package is incomplete. The notice shall identify any additional information or documentation that is needed to complete the application package.

(3) The department is exercising its authority under Section 14043.37, 14043.4, or 14043.7, and is conducting background checks, preenrollment inspections, or unannounced visits.

(4) The application package is denied for any of the following reasons:

(A) Pursuant to Section 14043.2 or 14043.36.

(B) For lack of a license necessary to perform the health care services or to provide the goods, supplies, or merchandise directly or indirectly to a Medi-Cal beneficiary, within the applicable provider of service category or subgroup of that category.

(C) The period of time during which an applicant or provider has been barred from reapplying has not passed.

(D) For other stated reasons authorized by law.

(e) (1) If the application package that was noticed as incomplete under subdivision (d) is resubmitted with all requested information and documentation, and received by the department within 35 days of the date on the notice, the department shall, within 60 days of the resubmission, send a notice that any of the following applies:

(A) The applicant or provider is being granted provisional provider status for a period of 12 months, effective from the date on the notice.

(B) The application package is denied for any other reasons provided for in paragraph (4) of subdivision (d).

(C) The department is exercising its authority under Section 14043.37, 14043.4, or 14043.7 to conduct background checks, preenrollment inspections, or unannounced visits.

(2) (A) If the application package that was noticed as incomplete under paragraph (2) of subdivision (d) is not resubmitted with all requested information and documentation and received by the department within 35 days of the date on the notice, the application package shall be denied by operation of law. The applicant or provider may reapply by submitting a new application package that shall be reviewed de novo.

(B) If the failure to resubmit is by a provider applying for continued enrollment, the failure shall make the provider also subject to deactivation of all provider numbers used by the provider to obtain reimbursement from the Medi-Cal program.

(C) Notwithstanding subparagraph (A), if the notice of an incomplete application package included a request for information or documentation related to grounds for denial under Section 14043.2 or 14043.36, the applicant or provider may not reapply for enrollment or continued enrollment in the Medi-Cal program or for participation in any health care program administered by the department or its agents or contractors for a period of three years.

(f) (1) If the department exercises its authority under Section 14043.37, 14043.4, or 14043.7 to conduct background checks, preenrollment inspections, or unannounced visits, the applicant or provider shall receive notice, from the department, after the conclusion of the background check, preenrollment inspections, or unannounced visit of either of the following:

(A) The applicant or provider is granted provisional provider status for a period of 12 months, effective from the date on the notice.

(B) Discrepancies or failure to meet program requirements, as prescribed by the department, have been found to exist during the preenrollment period.

(2) (A) The notice shall identify the discrepancies or failures, and whether remediation can be made or not, and if so, the time period within which remediation must be accomplished. Failure to remediate discrepancies and failures as prescribed by the department, or notification that remediation is not available, shall result in denial of the application by operation of law. The

applicant or provider may reapply by submitting a new application package that shall be reviewed de novo.

(B) If the failure to remediate is by a provider applying for continued enrollment, the failure shall make the provider also subject to deactivation of all provider numbers used by the provider to obtain reimbursement from the Medi-Cal program.

(C) Notwithstanding subparagraph (A), if the discrepancies or failure to meet program requirements, as prescribed by the director, included in the notice were related to grounds for denial under Section 14043.2 or 14043.36, the applicant or provider may not reapply for three years.

(g) If provisional provider status or preferred provisional provider status is granted pursuant to this section, a separate provider number shall be issued for each location for which an application package has been approved. This separate provider number shall be used exclusively for the location for which it is issued, unless the practice of the provider's profession or delivery of services, goods, supplies, or merchandise is such that services, goods, supplies, or merchandise are rendered or delivered at locations other than the provider's business address and this practice or delivery of services, goods, supplies, or merchandise has been disclosed in the application package approved by the department when the provisional provider status or preferred provisional provider status was granted.

(h) Except for providers subject to subdivision (c) of Section 14043.47, a provider currently enrolled in the Medi-Cal program at one or more locations who has submitted an application package for enrollment at a new location or a change in location pursuant to subdivision (a) may continue to submit claims under an existing provider number for services rendered at the new location until the application package is approved or denied under this section, and shall not be subject, during that period, to deactivation of the provider's provider number, or be subject to any delay or nonpayment of claims as a result of the use of the existing provider number for services rendered at the new location as herein authorized. However, the provider shall be considered during that period to have been granted provisional provider status or preferred provisional provider status and be subject to termination of that status pursuant to Section 14043.27. A provider that is subject to subdivision (c) of Section 14043.47

may come within the scope of this subdivision upon submitting documentation in the application package that identifies the physician providing supervision for every three locations.

(i) An applicant or a provider whose application for enrollment, continued enrollment, or a new location or change in location has been denied pursuant to this section, may appeal the denial in accordance with Section 14043.65.

(j) (1) The 180-day time period specified in subdivision (d) for the processing of an application package pursuant to subdivision (a) shall not apply to independent nurse providers who are providing or seeking to provide in-home nursing care to an individual patient pursuant to one of the home- and community-based waiver programs or pursuant to the Early and Periodic Screening, Diagnosis and Treatment Program for Medi-Cal recipients under the age of 21 years.

(2) For the purposes of this section "independent nurse providers" are providers authorized under certain home- and community-based waivers and under the state plan to provide nursing services to Medi-Cal recipients in the recipients' own homes rather than in institutional settings.

(3) The time period for the processing and approval, or provisional approval, of a provider application package submitted by an independent nurse provider shall not exceed 30 days following receipt of the application package by the department.

(4) Payment for authorized services to approved providers, or provisionally approved providers, pursuant to this subdivision, shall be retroactive to the postmark date of the submission of the provider application package.

(k) (1) So as to ensure the availability of independent nurse providers to provide services for Medi-Cal recipients residing in managed care counties or who have private health insurance coverage, but whose managed care organization or private health insurance carrier does not cover in-home nursing care services, the department shall ensure that it, or its services payment contractor or agent or fiscal intermediary, provides payment for claims in a timely manner, notwithstanding any incapacity of any electronic payment system to recognize and adapt to the personal circumstances of those Medi-Cal recipients.

(2) For purposes of this subdivision, "payment for claims in a timely manner" means payment within 30 days, or less, from receipt of a completed claim.

(3) By January 1, 2007, the department shall cause its services payment contractor or agent or fiscal intermediary to upgrade any electronic payment system so as to eliminate the need for manual edits and overrides for, and to enable the electronic processing of, claims from independent nurse providers that would otherwise have to be submitted with paper attachments.

SEC. 5. Section 14126.023 of the Welfare and Institutions Code is amended to read:

14126.023. (a) The methodology developed pursuant to this article shall be facility specific and reflect the sum of the projected cost of each cost category and passthrough costs, as follows:

(1) Labor costs limited as specified in subdivision (c).

(2) Indirect care nonlabor costs limited to the 75th percentile.

(3) Administrative costs limited to the 50th percentile.

(4) Capital costs based on a fair rental value system (FRVS) limited as specified in subdivision (d).

(5) Direct passthrough of proportional Medi-Cal costs for property taxes, facility license fees, new state and federal mandates, caregiver training costs, and liability insurance projected on the prior year's costs.

(b) The percentiles in paragraphs (1) through (3) of subdivision (a) shall be based on annualized costs divided by total resident days and computed on a specific geographic peer group basis. Costs within a specific cost category shall not be shifted to any other cost category.

(c) The labor costs category shall be comprised of a direct resident care labor cost category, an indirect care labor cost category, and a labor-driven operating allocation cost category, as follows:

(1) Direct resident care labor cost category which shall include all labor costs related to routine nursing services including all nursing, social services, activities, and other direct care personnel. These costs shall be limited to the 90th percentile.

(2) Indirect care labor cost category which shall include all labor costs related to staff supporting the delivery of patient care including, but not limited to, housekeeping, laundry and linen,

dietary, medical records, inservice education, and plant operations and maintenance. These costs shall be limited to the 90th percentile.

(3) Labor-driven operating allocation shall include an amount equal to 8 percent of labor costs, minus expenditures for temporary staffing, which may be used to cover allowable Medi-Cal expenditures. In no instance shall the operating allocation exceed 5 percent of the facility's total Medi-Cal reimbursement rate.

(d) The capital cost category shall be based on a FRVS that recognizes the value of the capital related assets necessary to care for Medi-Cal residents. The capital cost category includes mortgage principal and interest, leases, leasehold improvements, depreciation of real property, equipment, and other capital related expenses. The FRVS methodology shall be based on the formula developed by the department that assesses facility value based on age and condition and uses a recognized market interest factor. Capital investment and improvement expenditures included in the FRVS formula shall be documented in cost reports or supplemental reports required by the department. The capital costs based on FRVS shall be limited as follows:

(1) For the 2005–06 rate year, the capital cost category for all facilities in the aggregate shall not exceed the department's estimated value for this cost category for the 2004–05 rate year.

(2) For the 2006–07 rate year and subsequent rate years, the maximum annual increase for the capital cost category for all facilities in the aggregate shall not exceed 8 percent of the prior rate year's FRVS cost component.

(3) If the total capital costs for all facilities in the aggregate for the 2005–06 rate year exceeds the value of the capital costs for all facilities in the aggregate for the 2004–05 rate year, or if that capital cost category for all facilities in the aggregate for the 2006–07 rate year or any rate year thereafter exceeds 8 percent of the prior rate year's value, the department shall reduce the capital cost category for all facilities in equal proportion in order to comply with paragraphs (1) and (2).

(e) For the 2005–06 and 2006–07 rate years, the facility specific Medi-Cal reimbursement rate calculated under this article shall not be less than the Medi-Cal rate that the specific facility would have received under the rate methodology in effect

as of July 31, 2005, plus Medi-Cal's projected proportional costs for new state or federal mandates for rate years 2005–06 and 2006–07, respectively.

(f) The department shall update each facility specific rate calculated under this methodology annually. The update process shall be prescribed in the Medicaid state plan, regulations, and the provider bulletins or similar instructions described in Section 14126.027, and shall be adjusted in accordance with the results of facility specific audit and review findings in accordance with subdivisions (h) and (i).

(g) *(1)* The department shall establish rates pursuant to this article on the basis of facility cost data reported in the integrated long-term care disclosure and Medi-Cal cost report required by Section 128730 of the Health and Safety Code for the most recent reporting period available, and cost data reported in other facility financial disclosure reports or supplemental information required by the department in order to implement this article.

(2) The rates shall exclude the extra services and equipment related to a resident's transition from the facility to the community, including, but not limited to, transitional targeted case management provided pursuant to Section 14132.43 and home assessment by an occupational therapist.

(h) The department shall conduct financial audits of facility and home office cost data as follows:

(1) The department shall audit facilities a minimum of once every three years to ensure accuracy of reported costs.

(2) It is the intent of the Legislature that the department develop and implement limited scope audits of key cost centers or categories to assure that the rate paid in the years between each full scope audit required in paragraph (1) accurately reflects actual costs.

(3) For purposes of updating facility specific rates, the department shall adjust or reclassify costs reported consistent with applicable requirements of the Medicaid state plan as required by Part 413 (commencing with Section 413.1) of Title 42 of the Code of Federal Regulations.

(4) Overpayments to any facility shall be recovered in a manner consistent with applicable recovery procedures and requirements of state and federal laws and regulations.

(i) (1) On an annual basis, the department shall use the results of audits performed pursuant to subdivision (h), the results of any federal audits, and facility cost reports, including supplemental reports of actual costs incurred in specific cost centers or categories as required by the department, to determine any difference between reported costs used to calculate a facility's rate and audited facility expenditures in the rate year.

(2) If the department determines that there is a difference between reported costs and audited facility expenditures pursuant to paragraph (1), the department shall adjust a facility's reimbursement prospectively over the intervening years between audits by an amount that reflects the difference, consistent with the methodology specified in this article.

(j) For nursing facilities that obtain an audit appeal decision that results in revision of the facility's allowable costs, the facility shall be entitled to seek a retroactive adjustment in its facility specific reimbursement rate.

(k) Compliance by each facility with state laws and regulations regarding staffing levels shall be documented annually either through facility cost reports, including supplemental reports, or through the annual licensing inspection process specified in Section 1422 of the Health and Safety Code.

SEC. 6. Section 14132.43 is added to the Welfare and Institutions Code, to read:

14132.43. (a) (1) Targeted case management pursuant to Section 1915(g) of the Social Security Act (42 U.S.C. Sec. 1396n(g)), shall be a covered benefit of the Medi-Cal program for residents of nursing facilities when medically necessary to transition from a nursing facility into the community.

(2) Targeted case management shall be considered medically necessary when beyond the scope of the limited discharge planning services available from the nursing facility itself or when there is a need to supplement the discharge planning services available from the nursing facility.

(b) Case management provided by health care professionals employed by the department may also be used at the department's discretion to provide transitional case management services.

(c) (1) Six hours of targeted case management services without prior authorization may be provided once to any nursing

facility resident at the resident's request, including, but not limited to, a family member, when the resident or involved family member indicates a desire to return to the community but encounters barriers to a return.

(2) The targeted case management provider shall interview the nursing facility resident and others including the facility discharge planner, investigate options and barriers, and provide a written assessment setting out what would be required to enable the resident to transition into the community.

(d) Any utilization controls put in place by the department shall provide that a nursing facility resident may receive transitional targeted case management for up to eight months while in a nursing facility and for up to eight months following discharge from a nursing facility. The service months need not be sequential. Any utilization controls shall provide for expedited review of a request for authorization for additional hours beyond those initially authorized because of exigent but not emergency needs.

(e) Medi-Cal recipients who have been discharged from a nursing facility and who received transition targeted case management services to enable them to do so shall be entitled to short-term emergency targeted case management to address problems putting the former nursing facility resident's health at risk or that could trigger a return to a nursing facility.

(f) Targeted case management under this section is not intended to supplant the case management available to clients of regional centers under subdivisions (a) and (b) of Section 14132.48.

(g) The case management services provided shall include, but shall not be limited to, services to gain access to the medical, social, educational, and other services needed to ensure a safe and successful transition from the nursing facility to the community. Depending on individual need, those services may include any of the following:

(1) Arranging for application and assessments so that Medi-Cal personal care services would be in place upon going home and providing assistance in finding attendants.

(2) Assistance with housing including identifying subsidized housing or vouchers under Section 8 of the United States Housing Act of 1937 or other affordable housing that may be

available to nursing facility residents on an expedited basis, taking steps necessary to ensure the nursing facility resident's own home or home to which he or she may be moving is safe, accessible, and ready.

(3) Ensuring that the nursing facility resident is discharged with the durable medical equipment and supplies needed.

(4) Ensuring that family members and others providing care have an opportunity to be trained at the nursing facility prior to the resident's discharge and that the training includes materials, including videotapes when appropriate, to which they can refer to refresh themselves with respect to the services they will be providing.

(5) Linking the nursing facility resident with needed health care providers upon discharge.

(6) Ensuring the nursing facility resident will be able to get to doctor or clinic appointments.

(7) Identifying and linking former nursing facility residents up with other resources that would support them in the community, including, but not limited to, meals on wheels programs, programs that donate furniture and appliances, paratransit transportation, programs through independent living centers, programs providing social support, and programs matching up roommates for shared housing.

(8) Assisting the nursing facility resident in applying for applicable home- and community-based waivers when appropriate by ensuring all necessary documentation is provided to enable speedy processing of the waiver applications.

(9) Assisting the nursing facility resident in making contact with the federal Social Security Administration if the resident is currently receiving Supplemental Security Income (SSI) or would probably be receiving SSI if they were in the community, so that they receive benefits at the community standard when they are discharged.

(h) Targeted case management services under this section shall be provided pursuant to a plan developed with the nursing facility resident and agreed to by the resident. However, the ability of the targeted case manager to be able to use the authorized hours in a flexible manner is essential to the effectiveness of transitional case management. With the nursing

facility resident's approval, the transition assessment shall be incorporated into the resident's plan of care.

(i) The following entities are qualified to provide transitional targeted case management to residents of nursing facilities:

(1) Programs, agencies, or entities providing case management through Multipurpose Senior Service Programs (MSSP).

(2) Agencies or entities other than home health agencies providing case management services under the nursing facility home- and community-based waivers.

(3) Agencies and entities that have been vendored to provide case management services under the home- and community-based waiver serving persons with developmental disabilities.

(k) (1) The department shall adopt emergency regulations to implement this section in accordance with the rulemaking provisions of the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code).

(2) The emergency regulations shall be adopted when necessary federal approvals have been obtained or with respect to which the department determines that federal financial participation is available under Title XIX of the federal Social Security Act.

(3) The initial adoption and one readoption of the initial regulations shall be deemed to be an emergency and necessary for the immediate preservation of the public peace, health and safety, or general welfare.

(4) The initial emergency regulations and the first readoption shall be exempt from review by the Office of Administrative Law, however, the regulations shall be submitted to the Office of Administrative Law for filing with the Secretary of State, shall be published in the California Code of Regulations, and shall remain in effect as emergency regulations for no more than 180 days.

SEC. 7. Section 14132.99 is added to the Welfare and Institutions Code, to read:

14132.99. (a) For the purposes of this section, "facility residents" means individuals who are currently residing in a nursing facility and whose care is paid for by Medi-Cal either with or without a share of cost. The term "facility residents" also

includes individuals who are hospitalized and who are or will be waiting for transfer to a nursing facility.

(b) Additional slots beyond those currently authorized in the following home- and community-based waivers shall be added so that the needs of persons over 65 years of age can be met and so that facility residents have access to waiver slots without being put on a waiting list, as follows:

(1) For the current home- and community-based subacute nursing facility waiver, an additional 50 slots.

(2) For the current home- and community-based Level A/B nursing facility waiver, an additional 500 slots.

(3) For the current Multipurpose Senior Services Program waiver, an additional 300 slots that may be used by any program site on a first-come first-serve basis.

(c) One-half of the additional slots shall be available to those who qualify for Medi-Cal based on institutional deeming. The slots, however, shall be filled on a first-come basis without regard to the need for institutional deeming.

(d) For those facility residents who are in acute care hospitals with onsite Medi-Cal consultants and who are pending placement in a nursing facility, the department shall develop fast-track procedures for expediting the processing of waiver applications in order to divert hospital discharges from nursing facilities into the community.

(e) The subacute nursing facility and nursing facility Level A/B waivers shall be amended to add the following services, to extend eligibility to those who qualify for Medi-Cal on the basis of age, and to change cost-effectiveness measures:

(1) One-time community transition services as defined by the federal Centers for Medicare and Medicaid Services in the May 9, 2002, State Medicaid Directors Letter No. 02-008, including, but not limited to, security deposits that are required to obtain a lease on an apartment or home, essential furnishings, and moving expenses required to occupy and use a community domicile, set-up fees, or deposits for utility or service access, including, but not limited to, telephone, electricity, and heating, and health and safety assurances, including, but not limited to, pest eradication, allergen control, or one-time cleaning prior to occupancy.

(2) Habilitation services, as defined in Section 1915(c)(5) of the Social Security Act (42 U.S.C. Sec. 1396n(c)(5)), and in

attachment 3-d to the July 25, 2003, State Medicaid Directors Letter re Olmstead Update No. 3, to mean services designed to assist individuals in acquiring, retaining, and improving the self-help, socialization, and adaptive skills necessary to reside successfully in home- and community-based settings.

(3) Individuals who qualify for Medi-Cal on the basis of age shall be eligible for waiver services on the same basis as persons who qualify for Medi-Cal on the basis of disability.

(4) The individual cost-effectiveness standard to be applied to the facility residents receiving one of the priority slots shall be based on the actual or projected cost of the facility plus ancillary services if that aggregate cost is more than the cost used to determine individual cost-effectiveness for other waiver participants.

(5) The three waivers listed in subdivision (b) shall be amended to exclude from the cost-effectiveness formula for waiver participants any Medi-Cal cost that would be incurred regardless of whether the facility resident waiver participant were in the facility or community, including, but not limited to, medications.

(f) At the time of renewing any of the above three waivers listed in subdivision (b), the number of slots shall be increased to the extent necessary to ensure that nursing facility residents are able to receive waiver services when needed.

(g) This section shall be implemented when the department is satisfied that the requested state plan waivers or amendments can be implemented with federal financial participation with respect to the covered services. The request for nursing facility waivers and Multipurpose Senior Services Program waivers necessary to implement this section shall be submitted to the federal Centers for Medicare and Medicaid Services by April 1, 2006.

SEC. 8. If the Commission on State Mandates determines that this act contains costs mandated by the state, reimbursement to local agencies and school districts for those costs shall be made pursuant to Part 7 (commencing with Section 17500) of Division 4 of Title 2 of the Government Code.

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